Supreme Court, U.S.
FILED
AUG 2 - 2004
OFFICE OF THE CLERK

(2)

No. 03-1609

In the Supreme Court of the United States

PROVIDENCE HEALTH SYSTEM-WASHINGTON, DBA PROVIDENCE YAKIMA MEDICAL CENTER, DBA PROVIDENCE YAKIMA MEDICAL CENTER SKILLED NURSING FACILITY, PETITIONER

v.

TOMMY G. THOMPSON, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

The Secretary of Health and Human Services has issued a Medicare regulation, 42 C.F.R. 413.30(e) (1995), that was in effect only for cost reporting periods beginning before July 1, 1998. The question presented is whether the Secretary permissibly interpreted that regulation to determine that petitioner was not a "new provider" based on its acquisition of rights to operate skilled nursing beds from a previously-existing facility.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 5a-17a) is reported at 353 F.3d 661. The opinion of the district court (Pet. App. 18a-32a) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 3a-4a) was entered on December 17, 2003. The petition for rehearing was denied on March 1, 2004 (Pet. App. 1a-2a). The petition for a writ of certiorari was filed on May 28,

2004. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

This action involves the Secretary's interpretation of his regulation providing for a "new provider" exemption from Medicare's routine service cost limits. The regulation was an aspect of the "reasonable cost" system of Medicare reimbursement and it no longer applies under the "prospective payment system" that has been in effect for skilled nursing facilities for cost reporting periods beginning on or after July 1, 1998. 42 U.S.C. 1395yy(e)(1), (2)(D) and (E); 42 C.F.R. 413.1(g)(2)(i).

1. Under the "reasonable cost" system of reimbursement under the Medicare Act, Congress limited the amount that skilled nursing facilities could receive in reimbursement for non-capital routine service costs. 42 U.S.C. 1395x(v)(7)(D), 1395yy(a). The Act specifies that the Secretary of Health and Human Services (HHS) "may make adjustment in the limits * * * to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility." 42 U.S.C. 1395yy(c). In 1979, the Secretary promulgated a regulation, 42 C.F.R. 413.30(e), that exempted a "new provider" from the routine cost limits otherwise applicable to skilled nursing facilities. The regulation was designed to address the "problem[] of initial underutilization" sometimes faced by new inpatient skilled nursing facilities. 44 Fed. Reg. 31,802 (1979). The regulation defines the term "new provider" as a "provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and *previous ownership*, for less than three full years." 42 C.F.R. 413.30(e)(1995) (emphasis added). The regulation does not define the phrase "previous ownership."

2. Petitioner is a Medicare-certified skilled nursing facility located in the city and county of Yakima, Washington. The State requires any new health care entity to obtain a "Certificate of Need." Pet. App. 6a-7a. The State, in some areas, has imposed a moratorium on the addition of new nursing facility beds, but the State permits entities in moratorium areas to purchase the rights to operate existing beds from other facilities.

In 1990, petitioner purchased the rights to operate twelve nursing facility beds from an existing nursing facility, Summitview, which allowed petitioner to obtain a certificate of need from the State of Washington. Petitioner thereafter requested a "new provider" exemption under 42 C.F.R. 413.30(e). The request was denied by the fiscal intermediary responsible for the initial processing of Medicare reimbursement claims. The Provider Reimbursement Review Board (Board) within HHS affirmed, holding that petitioner did not qualify as a new provider under the regulation. Pet. App. 33a-65a. The Board adopted the intermediary's conclusion that the regulation requires a "review the operation of the entire institution under past and present ownership to determine if the institution has operated as the type of provider or its equivalent for less than three full years," and that it was appropriate to determine "if the institution has undergone a change of ownership * * * to ensure that the operation of the institution, under past and present ownership, is properly considered." *Id.* at 49a. The Board also found that the petitioner's facility had undergone a change of ownership by virtue of its purchase of operating bed rights from Summitview and accordingly that Summitview's operating history was properly considered in determining that petitioner was not a new provider. *Id.* at 61a-64a.

3. The district court reversed, Pet. App. 18a-32a, holding that the Board's decision "was contrary to the plain meaning of the regulation," *id.* at 26a.

4. The court of appeals reversed and remanded for the entry of judgment in favor of the Secretary. Pet. App. 1a-17a. The court of appeals observed that "[t]he critical question here is whether that characteristic of [petitioner's] operations that makes it a provider—the provision of inpatient services—can be said to have been previously owned by Summitview." *Id.* at 10a. The court held that "the plain language of 42 C.F.R. § 413.30(e) does not clearly address whether Summitview's ownership of the bed rights it transferred to [petitioner] constitutes previous ownership." Pet. App. 10a. The court also concluded the Secretary permissibly "chose to narrow its determination of [petitioner's] previous ownership to the question of whether the bed rights were previously owned by another [skilled nursing facility]," because "bed rights are an essential characteristic of providership." *Id.* at 12a.

The court of appeals also found that the Secretary's construction of 42 C.F.R. 413.30(e) (1995) "reasonably conforms to the * * * purpose" of the regulation. Pet. App. 16a. The court explained that in States like Washington, where there is a "de facto moratorium" on certain healthcare facilities, the Secretary "reasonably decided that no additional benefit is gained in the overall delivery of health care services when beds are merely shifted from one provider to another." *Id.* at 15a. The court similarly reasoned that because "providers in moratorium states will tend to suffer less from the effects of competition and any initial under-utilization, the Secretary has reasonably determined that they have less of a need for the exemption." *Ibid.*

ARGUMENT

1. a. The court of appeals correctly held that the Secretary permissibly construed his regulation, 42 C.F.R. 413.30(e) (1995), to exclude providers such as petitioner who are licensed by the State as skilled nursing facilities only by virtue of the purchase of the right to operating beds from a pre-existing facility. The regulation provides that a new provider is one that has operated for less than three full years under both present and "previous ownership," but the regulation does not specify the circumstances in which a provider may have undergone a change of ownership based on the purchase of any particular type or number of assets from another facility. Pet. App. 11a ("[T]he interplay of 'provider' and 'previous ownership' renders the regulation inherently ambiguous as to the critical question at issue in this case."); accord *South Shore Hosp., Inc.* v. *Thompson*, 308 F.3d 91, 98 (1st Cir. 2002); *Paragon Health Network* v. *Thompson*, 251 F.3d 1141, 1148 (7th Cir. 2001). The Secretary accordingly had the latitude to focus on the purchase of operating rights from a pre-existing facility when those rights were an essential feature of the provider's existence and right to operate under state law. See generally *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994) (Secretary's interpretation of his Medicare regulations is entitled to "substantial deference.").

Moreover, sound reasons justify the Secretary's interpretation. The new provider exemption was not intended to reimburse a provider for the start-up capital costs of building a new facility. Pet. App. 49a. Indeed, the exemption related to routine *operating* costs, not capital costs, 42 U.S.C. 13955yy, and was designed to guard against the risk of underutilization by newly constituted facilities, 44 Fed. Reg. 31,802 (1979). Accordingly, the

Secretary reasonably determined that in moratorium States that place caps on the number of operating beds that may exist in a geographic area, a provider who has purchased the right to operate beds from a pre-existing facility in the same geographic area is not likely to face underutilization by patients. *South Shore Hosp.*, 308 F.3d at 101; *Paragon Health Network*, 251 F.3d at 1149; see *Maryland Gen. Hosp.* v. *Thompson*, 308 F.3d 340, 347 (4th Cir. 2002) (observing that the Secretary's interpretation of the regulation "may well be reasonable when considered against the realities of the skilled nursing industry," and that "the Secretary might reasonably believe that the new provider exemption should be applicable only when a new facility increases the options available to the community it serves by increasing the number of beds actually in use in that community.").

b. Petitioner argues that this Court's review is warranted to resolve a conflict in the circuits whether the Secretary's construction of 42 C.F.R. 413.30(e) (1995) conflicts with the text of the regulation. Pet. 4-13. In contrast to the decision below, which joined in the conclusion of the First Circuit in *South Shore Hosp.*, *supra*, and the Seventh Circuit's decision in *Paragon Health Network*, *supra*, the Fourth and Sixth Circuits have found that the regulation is plain in including facilities such as petitioner's. *Ashtabula County Med. Ctr.* v. *Thompson*, 352 F.3d 1090, 1097 (6th Cir. 2003); *Maryland Gen. Hosp.* v. *Thompson*, 308 F.3d at 346. That conflict, however, does not warrant this Court's review because the regulation at issue only applies to skilled nursing facilities seeking reimbursement for routine operating costs for cost reports for reporting periods beginning before July 1, 1998. For cost reporting periods beginning on or after July 1, 1998, such facilities are reimbursed pursuant to Medicare's

prospective payment system, under which the Secretary's new provider regulation has no application. 42 U.S.C. 1395yy(e)(1), (2)(D) and (E); 42 C.F.R. 413.1(g)(2)(i). Nor is the fiscal impact of the question presented so substantial as to justify intervention by this Court despite the change in the law that went into effect more than six years ago. To the contrary, the Secretary informs us that the total amount in controversy for the nine "new provider" exemption cases involving the purchase of bed rights, including the decision below, that are pending either before HHS or the courts is less than $15 million.

2. Petitioner also argues (Pet. 13-19) that this Court's review is warranted to determine whether an agency's interpretation of its own regulation warrants substantial deference in light of the Court's decision in *United States* v. *Mead Corp.*, 533 U.S. 218 (2001), and *Christensen* v. *Harris County*, 529 U.S. 576 (2000). Petitioner did not advance that contention in the court of appeals, however, and this Court should decline to consider the issue in the first instance. *E.g.*, *Davis* v. *United States*, 495 U.S. 472, 489 (1990) ("Because this argument was neither raised before nor decided by the Court of Appeals, we decline to address it here.").

In any event, *Mead* and *Christensen* provide no basis for reconsideration of the settled principle that an agency's interpretation of its own regulation should be given "controlling weight unless it is plainly erroneous or inconsistent with the regulation," *Thomas Jefferson Univ.*, 512 U.S. at 512, and petitioner cites to no decision (nor are we aware of any) holding to the contrary. *Mead* and *Christensen* concerned the level of deference due to agency interpretations of statutes where the agency had not promulgated a relevant regulation. *Mead Corp.*, 533 U.S. at 227-238; *Christensen*, 529 U.S. at 587. And since those

decisions were rendered, the Court has reiterated that deference is owed to an agency's construction of its regulations. *Washington State Dep't of Soc. & Health Servs.* v. *Guardian Estate of Keffeler*, 537 U.S. 371, 387-388 (2003) ("[T]he Commissioner's interpretation of her own regulations is eminently sensible and should have been given deference."); *Barnhart* v. *Walton*, 535 U.S. 212, 217 (2002) ("Courts grant an agency's interpretation of its own regulations considerable legal leeway.").

Moreover, *Mead* explicitly recognized that deference is due when Congress would have so intended. 533 U.S. at 229-230. Under the Medicare program, Congress specifically granted the Secretary substantive rule-making authority to grant a routine costs exemption as the Secretary "deems appropriate," 42 U.S.C. 1395yy(c), and provided for formal administrative adjudication to resolve reimbursement claims under the Act and implementing regulations. 42 U.S.C. 1395oo. Interpretation of statutes in such adjudications are entitled to deference. *SEC* v. *Zandford*, 535 U.S. 813, 819-820 (2002). A fortiori, deference is owed to an agency's interpretation of its own regulations in such adjudications. In this case, the Secretary's interpretation of his regulations was articulated both in interpretive guidance and in the decision of the Provider Reimbursement Board in its adjudication of petitioner's claim. Pet. App. 8a, 12a-14a, 61a-65a. The court of appeals accordingly correctly deferred to the Secretary's construction of the regulation.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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AUGUST 2004